

NOTICE TO EMPLOYEE OF PAYMENT OF COMPENSATION WITHOUT PREJUDICE (G.S. § 97-18(d)) OR PAYMENT OF MEDICAL BENEFITS ONLY WITHOUT PREJUDICE (G.S. § 97-2(19) & § 97-25)

IC File # \_\_\_\_\_
Emp. Code # \_\_\_\_\_
Carrier Code # \_\_\_\_\_
Carrier File # \_\_\_\_\_

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name, Employer's Name, Telephone Number, Address, Employer's Address, City, State, Zip, Insurance Carrier, Policy Number, Home Telephone, Work Telephone, Carrier's Address, City, State, Zip, Last 4 Digits of SSN, Sex, Date of Birth, Carrier's Telephone Number, Fax Number

TO EMPLOYEE (TO DEPENDENT(S) OR NEXT OF KIN IN CASES OF DEATH):

This is to inform you with regard to your claim for

- injury on \_\_\_/\_\_\_/\_\_\_ (date) (Specify body part(s) involved):
occupational disease as of \_\_\_/\_\_\_/\_\_\_ (date) (Specify condition(s) and body part(s) involved):
death on \_\_\_/\_\_\_/\_\_\_ (date)

TO EMPLOYER/CARRIER: FILL OUT ONLY THE APPLICABLE SECTION 1 OR 2 BELOW

NOTE: THE FOLLOWING ARE FOR INFORMATIONAL PURPOSES ONLY AND DO NOT CONSTITUTE AN AGREEMENT

SECTION 1: INDEMNITY BENEFITS

Payments of workers' compensation benefits, both indemnity (money) and medical, will be made without prejudice to later deny your claim or Defendants' liability.

The date on which Defendants first had written or actual notice of this claim was \_\_\_/\_\_\_/\_\_\_(date)

Disability began on \_\_\_/\_\_\_/\_\_\_(date) and the first payment of compensation is being mailed on \_\_\_/\_\_\_/\_\_\_ (date)

Subject to verification, employee's average weekly wage was \$\_\_\_\_\_, which results in a weekly compensation rate of \$\_\_\_\_\_.

SECTION 2: MEDICAL BENEFITS ONLY (PAID WITHOUT PREJUDICE, NOT SUBJECT TO 90-DAY REQUIREMENT IN SECTION 1 ABOVE)

Payment of medical compensation is expressly being made without prejudice to Defendants to later deny the compensability of your claim.

The date on which Defendants first had written or actual notice of this claim was \_\_\_/\_\_\_/\_\_\_(date).

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR TITLE DATE

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML